

# SmartCare Connect (Group Health)

## Benefits at a Glance



**King County**

Benefits, Payroll and  
Retirement Operations

Plan Feature	Group Health Gold	Group Health Silver	Group Health Bronze
<b><i>Provider choice</i></b>	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There's no coverage for out-of-network care unless indicated and approved/referred.		
<b><i>Annual deductible</i></b>	None		
<b><i>Copay, unless otherwise indicated</i></b>	You pay \$20	You pay \$35	You pay \$50
<b><i>After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum</i></b>	Network: 100% Out-of-network: Limited emergency/out-of-area care		
<b><i>Annual out-of-pocket maximum</i></b>	Network: \$1,000/ person or \$2,000/ family Out-of-network: Limited emergency/out-of-area care	Network: \$2,000/ person or \$4,000/ family Out-of-network: Limited emergency/out-of-area care	Network: \$3,000/ person or \$6,000/ family Out-of-network: Limited emergency/out-of-area care
<b><i>After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level</i></b>	Network only: 100%		
<b><i>Lifetime maximum</i></b>	No limit		

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver	SmartCare Connect Bronze
<b><i>Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)</i></b>	Self-referrals to a network provider: \$20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services Massage therapy requires PCP referral and is covered under "rehabilitative services."	Self-referrals to a network provider: \$35 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services Massage therapy requires PCP referral and is covered under "rehabilitative services."	Self-referrals to a network provider: \$50 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services Massage therapy requires PCP referral and is covered under "rehabilitative services."
<b><i>Ambulance services</i></b>	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)		
<b><i>Applied behavioral analysis therapy for autism-spectrum disorders—outpatient</i></b>	\$20 copay No limit on number of days or visits. No age limit.	\$35 copay No limit on number of days or visits. No age limit.	\$50 copay No limit on number of days or visits. No age limit.
<b><i>Chemical dependency treatment (requires preauthorization)</i></b>	<i>For inpatient care:</i> 100% after \$200 copay/admission <i>For outpatient care:</i> 100% after \$20 copay/visit	<i>For inpatient care:</i> 100% after \$400 copay/admission <i>For outpatient care:</i> 100% after \$35 copay/visit	<i>For inpatient care:</i> 100% after \$600 copay/admission <i>For outpatient care:</i> 100% after \$50 copay/visit
<b><i>Chiropractic care and manipulative therapy (like all services, must be medically necessary)</i></b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<b><i>Diabetes care training</i></b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<b><i>Diabetes supplies (insulin, needles, syringes, lancets, etc.)</i></b>	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
<b><i>Durable medical equipment, prosthetics and orthopedic appliances</i></b>	80% when preauthorized	50% when preauthorized	50% when preauthorized

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver	SmartCare Connect Bronze
<b>Emergency room care</b>	<p>Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$200 copay/admission for hospital care applies if admitted)</p> <p>Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived, but \$200 copay/admission for hospital care applies if admitted)</p> <p><b>Non-emergency care is not covered.</b></p>	<p>Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$400 copay/admission for hospital care applies if admitted)</p> <p>Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived, but \$400 copay/admission for hospital care applies if admitted)</p> <p><b>Non-emergency care is not covered.</b></p>	<p>Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$600 copay/admission for hospital care applies if admitted)</p> <p>Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived, but \$600 copay/admission for hospital care applies if admitted)</p> <p><b>Non-emergency care is not covered.</b></p>
<b>Family planning</b>	<p>100% after \$20 copay/visit</p> <p><b>Infertility treatment is not covered.</b></p>	<p>100% after \$35 copay/visit</p> <p><b>Infertility treatment is not covered.</b></p>	<p>100% after \$50 copay/visit</p> <p><b>Infertility treatment is not covered.</b></p>
<b>Growth hormones</b>	Covered under prescription drugs if medical coverage has been continuous for more than 12 months under this plan whether or not the growth disorder existed before plan coverage		
<b>Hearing aids</b>	100%, up to \$300/ear in 36 months		
<b>Home health care</b>	100%		
<b>Hospice care</b>	100% when preauthorized Certain limits apply; call plan for details.		
<b>Hospital care</b>	100% after \$200 copay/admission	100% after \$400 copay/admission	100% after \$600 copay/admission
<b>Injury to teeth (only accidental injury covered—injury from biting and chewing not covered)</b>	<p>100% after \$20 copay/visit</p> <p>Treatment must be provided within 12 months of date of injury, except for children under age 14.</p>	<p>100% after \$35 copay/visit</p> <p>Treatment must be provided within 12 months of date of injury, except for children under age 14.</p>	<p>100% after \$50 copay/visit</p> <p>Treatment must be provided within 12 months of date of injury, except for children under age 14.</p>
<b>Inpatient care alternatives</b>	100% when preauthorized		
<b>Lab, X-ray and other diagnostic testing</b>	100%		
<b>Maternity care</b>	<p><i>For delivery and related hospital care:</i> 100% after \$200 copay/admission</p> <p><i>For prenatal and postpartum care:</i> 100% after \$20 copay/visit</p>	<p><i>For delivery and related hospital care:</i> 100% after \$400 copay/admission</p> <p><i>For prenatal and postpartum care:</i> 100% after \$35 copay/visit</p>	<p><i>For delivery and related hospital care:</i> 100% after \$800 copay/admission</p> <p><i>For prenatal and postpartum care:</i> 100% after \$50 copay/visit</p>

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver	SmartCare Connect Bronze
<b><i>Mental health care (requires preauthorization)</i></b>	<i>For inpatient care:</i> 100% after \$200 copay per admission <i>For outpatient care:</i> 100% after \$20 copay/individual, family, couple or group session	<i>For inpatient care:</i> 100% after \$400 copay per admission <i>For outpatient care:</i> 100% after \$35 copay/individual, family, couple or group session	<i>For inpatient care:</i> 100% after \$600 copay per admission <i>For outpatient care:</i> 100% after \$50 copay/individual, family, couple or group session
<b><i>Neurodevelopmental therapy</i></b>	<i>For inpatient care:</i> 100% after \$200 copay/admission <i>For outpatient care:</i> 100% after \$20 copay/visit	<i>For inpatient care:</i> 100% after \$400 copay/admission <i>For outpatient care:</i> 100% after \$35 copay/visit	<i>For inpatient care:</i> 100% after \$600 copay/admission <i>For outpatient care:</i> 100% after \$50 copay/visit
<b><i>Out-of-area coverage—for example, while traveling or for your covered children away at school</i></b>	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.		
<b><i>Phenylketonuria (PKU) formula</i></b>	100%		
<b><i>Physician and other medical/surgical services</i></b>	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$20 copay/office visit	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$35 copay/office visit	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$50 copay/office visit
<b><i>Prescription drugs—Up to a 30-day supply through network pharmacies</i></b>	Generic: 100% after \$10 copay Preferred brand: 100% after \$20 copay Non-preferred brand: 100% after \$30 copay Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.		
<b><i>Prescription drug—Up to a 90-day supply through mail-order network only</i></b>	Generic: 100% after \$20 copay Preferred brand: 100% after \$40 copay Non-preferred brand: 100% after \$60 copay		
<b><i>Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)</i></b>	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)
<b><i>Radiation therapy, chemotherapy and respiratory therapy</i></b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver	SmartCare Connect Bronze
<b>Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.</b>	100% depending on services provided; copays may apply (including \$200 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including \$400 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including \$600 copay/admission if hospital care is required)
<b>Rehabilitative services—Inpatient and outpatient</b>	<p><i>For inpatient care:</i> 100% after \$200 copay/admission, up to 60 days/calendar year</p> <p><i>For outpatient care:</i> 100% after \$20 copay/visit, up to 60 visits/calendar year</p>	<p><i>For inpatient care:</i> 100% after \$400 copay/admission, up to 60 days/calendar year</p> <p><i>For outpatient care:</i> 100% after \$35 copay/visit, up to 60 visits/calendar year</p>	<p><i>For inpatient care:</i> 100% after \$600 copay/admission, up to 60 days/calendar year</p> <p><i>For outpatient care:</i> 100% after \$50 copay/visit, up to 60 visits/calendar year</p>
<b>Skilled nursing facility</b>	100% up to 60 days/calendar year at a Group Health-approved nursing facility		
<b>Smoking cessation</b>	<p>100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Free &amp; Clear® Quit for Life™ Program, when prescribed by Group Health PCP</p> <p>No annual or lifetime limit</p>		
<b>Temporomandibular joint (TMJ) disorders</b>	<p><i>For inpatient care:</i> 100% after \$200 copay/admission</p> <p><i>For outpatient care:</i> 100% after \$20 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>	<p><i>For inpatient care:</i> 100% after \$400 copay/admission</p> <p><i>For outpatient care:</i> 100% after \$35 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>	<p><i>For inpatient care:</i> 100% after \$600 copay/admission</p> <p><i>For outpatient care:</i> 100% after \$50 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>
<b>Transplants (certain services only)</b>	<p>100% after applicable copays</p> <p>Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered.</p>		
<b>Urgent care (ear infections, high fevers, minor burns)</b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver	SmartCare Connect Bronze
<b><i>Vision exams</i></b>	100% after \$20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after \$35 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after \$50 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)

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